Merkel Independent School District

EMPLOYEE MEDICAL PLANS

Your medical benefits provide you with access to people, resources, and tools to help you when you aren't feeling your best. The plans have different levels of copays, deductibles, and out-of-pocket maximums. Make an informed decision by reading brief descriptions of your coverage options. The medical program, administered by **Baylor Scott and White**, provides the framework for your health and well-being.

Medical Premiums	Baylor Scott and White **Medical Cost Comparison**				
Monthly Rates	**BSW Plus HMO LE5HA1Y2**	**BSW Plus HMO LC5HA1J2**	**BSW Plus HMO LC5HA4F2**	**BSW Plus HMO CEP5HAQ2**	**BSW Access PPO UHB5J2I2**
Employee	$105.85	$279.32	$296.35	$138.17	$336.18
+ Spouse	$922.87	$1,391.12	$1,437.05	$1,010.11	$1,544.58
+ Child(ren)	$444.75	$740.50	$769.52	$499.85	$837.43
+ Family	$1,232.35	$1,812.25	$1,869.15	$1,340.38	$2,002.30

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

MEDICAL PLAN **COMPARISON**

	BSW Plus HMO LE5HA1Y2		BSW Plus HMO LC5HA1J2		BSW Plus HMO LC5HA4F2	
PLAN FEATURES (INDIVIDUAL/FAMILY)						
Type of Coverage	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$7,950/$15,900	Not Covered	$4,000/$8,000	Not Covered	$2,000/$4,000	N/A
Coinsurance	0% After Deductible	Not Covered	0% After Deductible	Not Covered	10% After Deductible	Not Covered
Max Out-of-Pocket	$8,300/$16,600	Not Covered	$7,000/$14,000	Not Covered	$5,000/$10,000	Not Covered
Primary Care Provider (PCP) Required	No	Not Covered	No	No	No	No
DOCTORS VISITS						
Primary Care	0% copayment after deductible	Not Covered	Adult: No charge for first visit; $25 copay per visit for subsequent visits; Pediatric: No charge	Not Covered	Adult: No charge for first visit; $25 copay per visit for subsequent visits; Pediatric: No charge	Not Covered
Specialist	0% copayment after deductible	Not Covered	$50 Copay	Not Covered	$50 Copay	Not Covered
IMMEDIATE CARE						
Urgent Care	0% copayment after deductible	0% copayment after deductible	$50 Copay	$50 Copay	$50 Copay	$50 Copay
Emergency Room	0% copayment after deductible	0% copayment after deductible	$500 copay, deductible does not apply	$500 copay, deductible does not apply	$500 Copay plus 10% coinsurance, deductible does not apply	$500 Copay plus 10% coinsurance, deductible does not apply
Preventive Care	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered
Diagnostic X-Ray and Labs	0% copayment after deductible	Not Covered	No Charge	Not Covered	No Charge	Not Covered
MRI, CAT Scan, PET Scan	0% copayment after deductible	Not Covered	$250 copayment per visit, deductible does not apply	Not Covered	10% After Deductible	Not Covered
Hospital In/Out Patient	0% copayment after deductible	Not Covered	0% after deductible	Not Covered	10% After Deductible	Not Covered
PRESCRIPTION DRUGS						
Retail (30-Day) Preferred Generic/ Non-Preferred Generic	Tier 1: $0 copay Tier 2: $0 copay	Not Covered	Tier 1: $0 copay Tier 2: $10 copay	Not Covered	Tier 1: $0 copay Tier 2: $10 copay	Not Covered
Retail (30-Day) Preferred Brand/ Non-Preferred Brand	Tier 3: $0 copay Tier 4: $0 copay	Not Covered	Tier 3: $50 copay Tier 4: $115 copay	Not Covered	Tier 3: $50 copay Tier 4: $115 copay	Not Covered
Specialty	Tier 1, 2, & 3: $0 copay after deductible	Not Covered	Tier 1: $100 copay Tier 2: $175 copay Tier 3: $350 copay	Not Covered	Tier 1: $100 copay Tier 2: $175 copay Tier 3: $350 copay	Not Covered
MAIL ORDER DRUGS						
90-day supply	2.5X retail	Not Covered	2.5X retail	Not Covered	2.5X retail	Not Covered

MEDICAL PLAN **COMPARISON**

	BSW Plus HMO CEP5HAQ2		BSW Access PPO UHB5J2I2	
PLAN FEATURES (INDIVIDUAL/FAMILY)				
Type of Coverage	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$7,500/$15,000	Not Covered	$3,500/$7,000	$7,000/$14,000
Coinsurance	20% After Deductible	Not Covered	20% After Deductible	50% After Deductible
Max Out-of-Pocket	$9,200/$18,400	Not Covered	$6,000/$12,000	$18,000/$36,000
Primary Care Provider (PCP) Required	No	No	No	No
DOCTORS VISITS				
Primary Care	Adult: No charge for first visit; $15 copay per visit for subsequent visits Pediatric: No charge	Not Covered	Adult: No charge for first visit; $25 copay per visit for subsequent visits Pediatric: No charge	50% coinsurance
Specialist	$45 Copay	Not Covered	$50 Copay	50% coinsurance
IMMEDIATE CARE				
Urgent Care	$50 Copay	$50 Copay	$50 Copay	$50 Copay
Emergency Room	$250 Copay per visit plus 20% coinsurance	$250 Copay per visit plus 20% coinsurance	$500 Copay per visit plus 20% coinsurance	$500 Copay per visit plus 20% coinsurance
Preventive Care	No Charge	Not Covered	No Charge	50% After Deductible
Diagnostic X-Ray and Labs	20% copayment after deductible	Not Covered	No Charge	50% After Deductible
MRI, CAT Scan, PET Scan	20% copayment after deductible	Not Covered	20% coinsurance	50% After Deductible
Hospital In/Out Patient	20% After Deductible	Not Covered	20% After Deductible	50% After Deductible
PRESCRIPTION DRUGS				
Retail (30-Day) Preferred Generic / Non-Preferred Generic	Tier 1: $5 copay Tier 2: $15 copay	Not Covered	Tier 1: $0 copay Tier 2: $10 copay	50% coinsurance
Retail (30-Day) Preferred Brand / Non-Preferred Brand	Tier 3: $60 copay Tier 4: $130 copay	Not Covered	Tier 3: $50 copay Tier 4: $115 copay	50% coinsurance
Specialty	Tier 1: $125 copay Tier 2: $200 copay Tier 3: $400 copay	Not Covered	Tier 1: $100 copay Tier 2: $175 copay Tier 3: $350 copay	50% coinsurance
MAIL ORDER DRUGS				
90-day supply	2.5X retail	Not Covered	2.5X retail	50% coinsurance